What programme interventions can Kenya implement to improve adolescent sexual and reproductive health outcomes?

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1401 Evaluation of Youth Interventions

Abstract

Partly due to commitment to these international protocols dating back to the mid-1990s, there has been increased attention in Kenya towards improving SRH outcomes of young people. However, ASRH outcomes have improved only marginally or in some cases worsened. Decision-makers working in the ASRH field are therefore keen on getting information that will help them make decisions on where to focus efforts and the specific interventions they need to put in place to enhance policy and programme effectiveness.

The African Institute for Development Policy is conducting a study to map ASRH programmes in Kenya and identify effective and promising interventions for improving ASRH outcomes in SSA for application in Kenya. Data are being gathered using a structured questionnaire and review of systematic reviews. The study provides recommendations to inform efforts to increase the coverage of ASRH programmes and investments in the most effective interventions.

Extended Abstract

Introduction and Background

Young people in Kenya are disproportionately vulnerable to poor sexual and reproductive health (SRH) outcomes such as sexually transmitted infections (STIs), HIV, unintended pregnancy and complications or death associated with early pregnancy and unsafe abortion relative. These poor SRH outcomes have far reaching negative effects on individual and national socioeconomic development. Being a nation that is characterized by a young population, decision-makers recognize the need for focused attention to ensure that adolescents SRH needs are met in order to maximize the Kenya's opportunity for harnessing the Demographic Dividend.

Partly due to commitment to these international protocols dating back to the mid-1990s, there has been increased attention in Kenya towards improving SRH outcomes of young people. However, the SRH indicators of young people, particularly of adolescents, have improved only marginally or in some cases worsened.

The latest Kenya Demographic and Health Survey (KDHS) released in May 2015 showed that Kenya's teenage pregnancy rate has increased from 17.7% in 2008-09 to 18% in 2014. Meanwhile, levels of contraceptive use and unmet need for contraceptives have improved. Contraceptive use increased from 20% to 37% and unmet need for contraceptives declined

from 30% to 23%. While the HIV prevalence among adolescents in Kenya decreased from 3% to 1% between 2008 and 2012, Kenya contributed 7% of all adolescents living with HIV globally in 2013. Child marriage and female genital mutilation (FGM), which predispose adolescents to a host of poor SRH outcomes, is still prevalent. Half of women aged 20-24 years were married by age 18 years and one-quarter of all women and one out of ten adolescents have undergone FGM. A recent national study on the incidence of unsafe abortion in Kenya found that 17% of women presenting for abortion-related care in the sampled facilities were adolescents aged 10-19 years. Nearly half of the women who presented with severe complications of unsafe abortions were adolescents aged 10-19 (45%).

The national statistics mask the socio-economic and regional inequities that exist in Kenya. For instance, girls without education are three times more likely to be pregnant or a mother than girls with secondary and higher education. Whereas, poor married women are two times less likely to use contraceptives than their urban and rich counterparts. Some communities still widely practice child marriage and FGM. In Northeaster Kenya, half of women aged 15-49 years were married by age 18 years relative to by 24 years in Nairobi and nearly all (97%) women aged 15-49 years have undergone FGM relative to 21% countrywide. Use of contraceptives by married women is also lowest in the Northeaster region (3.4%) relative to 58% countrywide. While the assumption would be that the teenage pregnancy rate would be highest in the Northeastern region given the high rates of child marriage and FGM, teenage pregnancy in that region is the second lowest level in the country (12%).

Decision-makers who make policy, programme and investment decisions on ASRH in Kenya are therefore keen on getting information that will help them make decisions on where to focus efforts and the specific interventions they need to put in place to enhance policy and programme effectiveness. However, a number of barriers are preventing them from meeting their information needs.

Barriers at operational level

Because of the weak capacity of most national governments to coordinate ASRH activities and do integrated planning (given the multisectoral nature of ASRH activities), decision-makers lack of knowledge of the coverage and focus of ASRH programmes being implemented in the country. There is also a lack of harmonization of the ASRH interventions being implemented across the country mainly because development partners and even government healthcare providers are unaware of prevailing ASRH policies, strategies and service provision guidelines due to poor dissemination of the documents stemming from limited financial resources to do so. Weak monitoring and evaluation also contributes to a lack of adherence to prescribed guidance for delivery of ASRH information and services.

Barriers to uptake of evidence in ASRH decision-making processes

Decision-makers in Kenya also lack access to empirical evidence illustrating what issues to invest in and which interventions are most effective at improving ASRH outcomes. On the one hand, the current evidence on the determinants and consequences of teenage pregnancies is not comprehensive making it difficult to tailor programmes for diverse adolescents. On the other hand, the available research evidence on ASRH is fragmented in various scientific journals and voluminous reports that are not accessible to most decision-makers.

This is further complicated by the lack of the technical capacity among decision-makers to translate and use research evidence. Therefore, the utility of existing evidence including systematic reviews that recommend interventions for improving ASRH outcomes has been limited. A majority of existing systematic reviews use technical language and have not been translated into formats that decision-makers can use. But even in cases where they have been translated into user-friendly formats, there has been limited efforts to proactively disseminate such reviews and therefore the evidence does not get to the tables of decision-makers.

To address some of the information barriers that ASRH decision-makers in Kenya face, the African Institute for Development Policy (AFIDEP), is conducting a study to map the coverage, focus and approaches of ASRH programmes in Kenya spanning the period between the 2008-09 KDHS and the 2014 KDHS. The study will also identify effective and promising interventions for improving ASRH outcomes in SSA for consideration for application in Kenya. The study began in June 2014 and is expected to be completed at the end of August 2015.

The evidence generated from the study will inform efforts to address gaps in ASRH programmes' focus and coverage and investments in the most effective interventions. This will in part lead to improved coverage of ASRH programmes and design of more effective ASRH programmes. Improved coverage and effectiveness of ASRH programmes will result in an increase in access to services by adolescents and ultimately improve ASRH outcomes.

Methodology

The study is ongoing with some components completed and other components not completed. Data is being gathered using a range of methods:

1. Mapping the coverage of ASRH programmes in Kenya including their areas of focus and approaches using a structured questionnaire adapted from one used by FHI360 in 2011 to conduct a similar assessment in Kenya. The mapping is scheduled to be completed in August 2015.

2. Desk review of published and grey literature on the coverage, focus and approaches of ASRH programmes in Kenya. This will be done to fill gaps in information collected using the mapping tool.
3. Review, synthesis and repackaging of existing evidence on best and promising practices from systematic reviews. After a comprehensive review of 15 articles on the effectiveness of 9 types of ASRH interventions, data extraction was undertaken using a standard Cochrane data extraction form. The effectiveness of the interventions was characterized based on the following criteria adapted from the Compassion Capital Fund National Resource Center. (undated).

The quantitative data will be analysed using descriptive statistics and the qualitative data will be subjected to thematic analysis. The findings will be synthesized to highlight the gaps in ASRH programme coverage and the key recommendations for improving ASRH programme coverage and effectiveness.

Limitation of the study

The study has a number of limitations including several related to comprehensiveness of the evidence. The mapping assessment does not include thorough review of programme documents and site visits to do observation. In addition, the systematic review is not exhausted and will be continually updated over the next year.

Preliminary results

Decision-makers in Kenya lack access to relevant information and evidence to support ASRH policy and programme decisions. Our study seeks to address some of the information gaps faced by decision-makers.

The mapping is scheduled to be completed in August 2015 and therefore, we do not yet have findings to report. We expect to see an overrepresentation of ASRH programmes focusing on HIV. We also expect to see a substantial level of programmes are focusing on preventing other STIs and teenage pregnancies with the recent push to integrate HIV and SRH services for young people. We also expect to see few programmes are providing comprehensive abortion care services given the sensitivity of abortion in Kenya. The assessment will verify our expectations.

The review of systematic reviews began in June 2014 until June 2015 and will be periodically updated over the next year. We have characterised mass media interventions as effective because the intervention has been widely replicated and strong evidence of effectiveness has been demonstrated in multiple contexts. We have characterized five interventions (comprehensive sex education, prevention of child marriage, conditional cash transfer, some community based interventions and youth friendly health services) as promising because there is a modest amount of evidence showing positive effectiveness

but replication is on a limited scale in the African setting or there is need for robust research designs to strengthen the existing evidence. One intervention (new media (e.g. social networking sites)) is characterised as emerging because there is evidence on positive effectiveness of various types of new media with little or no replication. Two interventions (peer education and youth centers) are characterised as inconclusive because the evidence is either against implementation or shows evidence in both direction.

Based on the review findings decision-makers should prioritise and invest in or advocate for investments in:

- Holistic programmes that combine a range of effective interventions aiming to engage young people in learning about and shaping their sexual and reproductive future.
- Scale-up of long-term mass media programmes tailored specifically to adolescents and use multiple media outlets. Programmes should incorporate research to assess the relative effectiveness of the various types of media approaches.
- Wide implementation of curriculum-based comprehensive sex education delivered by adults, horizontal and vertical prevention of child marriage, conditional cash transfer to keep girls in school and community based interventions that use a combination of facility and outreach targeting young people. Programmes should incorporate a strong evaluation component to clarify impact intervention and mechanisms of action.

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